U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Organizational Excellence

Spotlight ON EXCELLENCE

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https://www.va.gov/healthcareexcellence/

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https://vaww.rtp.portal.va.gov/OQSV/SitePages/Home.aspx

A Word from the Deputy Under Secretary:
Dr. Gerard R. Cox

Toward a Common Vision of Organizational Excellence

In the weeks since my appointment as Deputy Under Secretary for Health, many 10E staff have asked about my vision for the Office of Organizational Excellence. To address that question, I'd like to first reflect upon what I know to be true about 10E and what I believe is essential about our Office's service to Veterans.

What I know…

Our Nation's men and women put their lives and souls on the line for our protection, and while we may never truly know their heartache or pain, we honor their service by working to ensure they receive the highest quality care. Within 10E specifically, our work helps ensure that systems and processes in the field run smoothly, that quality and safety standards are promoted system-wide, and that accountability and oversight pervade all these activities.

I also know that we share a dedication to VA's mission, a factor that is affirmed over and over again in various venues – from responses to the Annual Employee Survey to feedback during our Conversations with Leadership sessions. I've now had the privilege to host four of these Conversations, and each time, I've been gratified to hear this commitment to mission expressed by many different staff members.

Further, I also know the following: to say VA has undergone tremendous change this past year is an understatement. In fact, it may be wise to acknowledge this dynamic as our constant, and seek to leverage its potential. As Sir Winston Churchill once observed: "A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty." I have found Churchill's words to ring true, both at VA as well as during my previous experience in the Navy. This past year, Team Excellence has proven itself to be both resilient and creative; two qualities that will serve us well moving forward.

What I believe…

As I mentioned in an Excellence Matters blog last summer, I believe it is essential for a leader to be visible, accessible and responsive to staff. In the blog, I noted my use of "walk arounds" in order to meet staff personally, and how I've worked over the past year to extend those walk arounds geographically, whether across the street at 811 Vermont during meetings with Integrity staff or across the country with other workgroups during site visits. As Deputy Under Secretary for Health, I remain committed to this standard, and look forward to meeting more members of Team Excellence in person.

I also believe that collaboration is essential to achieving our goals for Veterans. Over the past year, as Acting DUSHOE, it was my great privilege to work in partnership with

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10E's senior leadership, learning more, in particular, about the QSV Office, and discovering the various synergies with the Office of Integrity. However, due to the virtual nature of 10E, much of this work was accomplished via conference call, or occasional face-to-face meetings.

Therefore, as one of my first major initiatives for 10E, we are "amping up" our collaborative energies by meeting in person this December for a two-day retreat. For many of our leadership, particularly on the QSV side, it's been years since they've had a chance to meet face to face. The retreat will therefore be essential to helping many reconnect, as well as forging a common 10E voice. Further, in addition to learning more about the work of our offices and workgroups (a request expressed by many of our senior leaders), we'll talk about our collective role and involvement with higher-level VA and VHA initiatives including Modernization; the General Accounting Office-High Risk List; the SToP Fraud, Waste and Abuse initiative; and internal communications for the Three Lines of Defense. We'll also discuss VHA Executive in Charge Dr. Richard Stone's goal for VHA to become a High Reliability Organization. Additionally, in the true spirit of continuous learning, we'll revisit our mission and vision statements to see how they align with 10E's evolution as a program office, and look at better ways to communicate internally.

It is from these discussions that I expect a common vision for 10E to emerge. I look forward to reporting to you early next year about this vision, and working with you to carry it forward. ◆

Leadership Q&A: ERNEST MOY, M.D., M.P.H.

Executive Director Office of Health Equity

How would you describe what your office does for Veterans, to a Veteran?

I think a critical mission of the VA is to provide high-quality health care to all Veterans. Our office focuses on the "all Veterans" part of that mission. The Office of Health Equity (OHE) seeks to ensure that all Veterans receive the right care at the right time by the right providers. To do this, our office examines differences in the health care Veterans receive related to sex, age, geographic location, sexual orientation, socioeconomic status, disability, and race/ethnicity, including care for White, Black, Hispanic, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, and multiracial Veterans.

How does your office support VHA staff in the field?

OHE supports the VHA's vision to provide appropriate individualized health care to each Veteran in a way that eliminates disparate health outcomes and assures health equity. We do this by transferring data and information back to the field that is specific to different Veteran populations. The field can then focus resources on those Veteran populations at risk of not receiving the same quality care as others who can more easily access high-quality treatment.

What lessons can private sector health care learn from VHA health care?

Having worked outside the VA, I know that the private sector has a great deal of difficulty tracking health disparities among at-risk populations. Without the tracking abilities available within the VA through its electronic health records and clinical data warehouse, access and quality problems in specific population groups may go undetected. While differences in health care quality and health outcomes between different groups have been seen both inside and outside VA, these differences tend to be smaller within VA facilities than within non-VA facilities.

What projects, initiatives are you working on that our readers should know about?

OHE is an information processor. We are continuously working on improving our data collection systems that feed into a "dashboard" to help us target at-risk populations. Our goal is to streamline the process for a specific VA medical center to look at how it is doing in comparison to other VA medical centers through a cross-section of different measures and populations.

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How would you define the term quality, and how does Organizational Excellence function to advance or support it?

I would define quality within the VA as providing all Veterans with the right care, the right way, at the right time, in a way that is respectful of Veteran preferences and supportive of the best health outcomes. Equity is a critical component of quality that ensures that different groups of Veterans receive the same quality of health care needed to support their health and wellbeing. Within OE, we have a lot of expertise working on efficient and useful ways of tracking population health and health care preferences to help achieve the highest-quality health care for all Veterans.

Does OHE partner with any external organizations (e.g., other federal agencies, VSOs, nonprofits)?

Yes. Issues of equity that Veterans experience often spill over into care outside of VA. We are working and partnering with the U.S. Department of Health and Human Services to help identify risk factors in the general population and within community medical facilities that Veterans might access through Choice or on referral.

Why did you decide to work at VA?

I am a general internist and health researcher and have worked in the health equity field for a long time. I have written many reports on health disparities and equity, but not seeing this work translated into tangible change became disappointing. When I had the chance to lead the Health Equity Office within Organizational Excellence, I jumped at it so that I could help drive improvement through equity within the VA system and give back to our Veterans.

Can you share an experience you had with a Veteran, or at a facility, that was an "inspiring moment"?

In the earlier days of my career, I took care of a Korean War Veteran. He was in bad shape – no fingers or toes from frostbite — and I could only understand 10 percent of what he said. Eating with no digits is pretty messy, but he was always happy, well-dressed, and well-groomed. I came to realize this was because all the other Veterans receiving treatment in the 16-bed ward were taking care of him. This is what Veterans do — they show up and stand up for each other, never letting each other down. It was inspiring to see that kind of loyalty and brotherhood. ◆

Excellence in Action:

CART Program Improves Quality and Safety of Care for Patients Needing Invasive Cardiac Procedures

In 2004, a team of clinicians specializing in various invasive cardiac procedures, data analysts, and operational experts came together to form VA's Clinical Assessment, Reporting and Tracking (CART) program; an internal quality and safety organization. Until that time, VA had only limited data regarding the volume and clinical outcomes of cardiac procedures performed in its health care system.

To support this program, and as part of a multi-office collaboration, the Office of Clinical Systems Development and Evaluation (CSDE) developed state-of-the-art analytics that help ensure high-quality cardiac care for Veterans. (CSDE is the Organizational Excellence office that works toward the development of clinical systems that integrate quality and decision support into workflow and analytical programs. Products prepared by CSDE help VA facilities with patient care plan management, identification and evaluation of high-risk patients, biosurveillance, infection control, and optimized assessment and tracking for cardiovascular procedures.)

"CART represents an important model of embedding the process of quality and safety directly within workflow, helping translate information to the most critical points of relevancy – whether that is point-of-care decision-making or safety assessments," says Dr. Tami Box, Acting Director CSDE.

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In the years following the establishment of the CART Program, a dedicated software application linked to VA's electronic medical record, now known as the CART Application Suite (CART-APPS), was internally developed to allow providers to input patient and procedural information within the clinical workflow, completing required clinical documentation while simultaneously providing information for quality improvement and safety oversight. Today, CART captures information on more than 100,000 cardiac procedures performed by VA cardiologists each year actively investigating means to improve the quality and safety of invasive cardiac care.

To enhance the quality of care that Veterans receive, the CART Program develops predictive analytic models used as point-of-care tools for physicians to measure the risks and benefits of invasive cardiac procedures. "These risk estimates allow clinicians to determine the most appropriate therapies for their patients taking into account the unique characteristics of our Veteran population. Further, these calculators allow clinicians to discuss the risks of a given procedure with a patient, enabling everyone to make informed decisions about proceeding with an invasive procedure," says Stephen W. Waldo, MD, National Director of the VA CART Program.

CART monitors the safety of all invasive cardiac procedures through two distinct safety programs. The first monitors all major adverse events that occur during invasive cardiac procedures. These events are automatically reported to the CART Program via the CART-APPS. Upon notification, the major adverse event is then reviewed by a committee that includes 8-12 subject matter experts who review the case and determine if there are systems issues to address. All recommendations from this committee are routed back to the local site, and documents describing best practices for invasive procedures are distributed to VA clinicians at all facilities. The second program monitors cardiac device safety, through a partnership with the National Center for Patient Safety and the U.S. Food and Drug Administration (FDA). "There are plans to integrate CART-APPS with Real Time Logistic Services (RTLS) to make it possible for our program to monitor device failures in real-time, using active surveillance. We continually strive to find ways to integrate our technologies to improve quality and safety," says Meg Plomondon, CART Director of Analytics.

The CART Program provides internal reports about procedural volumes and clinical outcomes to each of the 80 cardiac catheterization laboratories within the VA system. "The CART program has been immeasurably useful to us at it provides us with an opportunity to measure our performance against other cath labs. By standardizing data entry in a convenient form, it creates a common language for us to communicate about a disparate group of procedural areas," says Dr. Crispin Davies, Deputy Chief of Cardiology, VA Portland Health Care System. In addition, the program develops analytic reports dictating the current effects of health care policy on patients. These reports detail information on the type of coronary stents utilized, the number of hybrid operating rooms employed and the suggested volumes to maximize the safety of transcatheter aortic valve replacement that are provided to stakeholders in VACO to inform policy decisions. According to Dr. Richard Schofield, National Program Director for Cardiology in the VA Office of Specialty Care, "The CART data is absolutely critical in allowing me to maintain oversight of cardiovascular procedure volumes and complication rates within VA cardiac catheterization laboratories. I routinely rely on CART for information that helps me to shape important national operational and policy decisions that impact cardiovascular care." ◆

Feature from the Field:
Internal Audit and Risk Assessment (IARA)

The Office of Internal Audit and Risk Assessment (IARA) monitors and evaluates the effectiveness of VHA governance, risk management and internal controls. Established in 2016 as an independent assurance organization at VHA, IARA and the Office of the Medical Inspector serve as the third line of defense in the Three Lines of Defense (3LD) model outlined in the summer issue of Spotlight on Excellence.

In 2015, the Under Secretary for Health (USH) consolidated VHA program offices responsible for oversight and accountability under a single Assistant Deputy Under Secretary for Health. Along with IARA, the Office of Compliance and Business Integrity, the Office of the Medical Inspector, and the National Center for Ethics in Health Care comprise the Office of Integrity at OE. IARA reports to the VHA Audit, Risk and Compliance Committee (ARCC). "IARA is independent of management to ensure that it can maintain independence and objectivity," says Ms. Deborah Kramer, IARA Chief Audit Executive and Executive Director. IARA determines what to audit based on an enterprise risk assessment. The risk assessment is coordinated with and approved by the ARCC. IARA then conducts an audit feasibility assessment (AFA)

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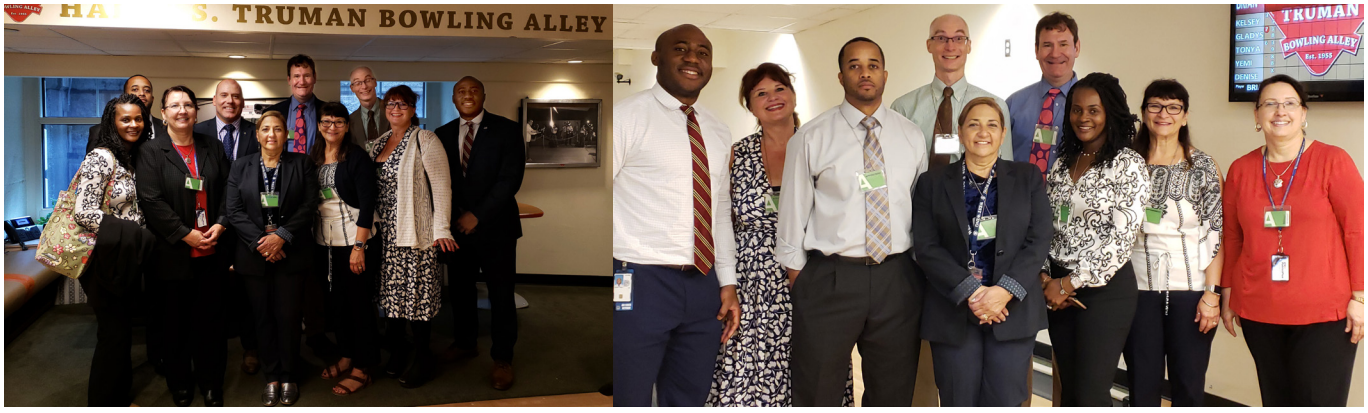
for each of the ARCC-approved top risks. The AFA is an in-depth evaluation of the "auditability" of the risk. To determine "auditability," IARA reviews all related policy directives, handbooks, memorandums and national standards for the risk area. If the related policy is stable (not undergoing a change), and there are sufficient data available, the risk area is "auditable." When all AFAs are completed, IARA presents a proposed audit plan to the ARCC, and with ARCC concurrence, provides the Executive in Charge (EIC)/USH with the proposed audit plan. The EIC/USH then makes the final decision on what IARA will audit each year.

IARA is also the executive secretariat for VHA's ARCC – which provides governance, strategic guidance and direction for all VHA internal audit, risk assessment and compliance activities.

As the secretariat, IARA serves as the primary staff support for the ARCC.

IARA recently completed its inaugural assurance audit: evaluating the accuracy and reliability of Appointment Scheduling and Veteran Wait Times in 15 VA Medical Centers. IARA will conduct up to three more audits in fiscal year 2019. The topics are now undergoing AFAs, and IARA will present its proposed audit plan to the ARCC in November 2018.

In his previous column, Dr. Cox underscored the importance of implementing and promoting the 3LD model throughout VHA. As such, the model would be lacking without open lines of communication between auditors and stakeholders. Effective communication enables IARA to implement an internal audit and risk assessment program, which enhances VHA's oversight and accountability activities and ensures the end goal that Veterans receive the best health care possible, at the right time in the right place. ◆



IARA staff at a team-building offsite at the Truman Bowling Alley, Eisenhower Executive Office Building.

What's Happening at OE

The Office of Organizational Excellence invites you to send your events, conferences and publications for inclusion in this quarterly calendar. Please email your information to VHA10EDUSHOE1@va.gov.

December

Patient Flow Coordination Collaborative Learning Session 3 (Office of Systems Redesign & Improvement and the Office of Emergency Medicine)

December 11-13

Location TBD

Participants attend the Leadership panel discussion during Learning Session 3 of the Patient Flow Coordination Collaborative, December 11-13.

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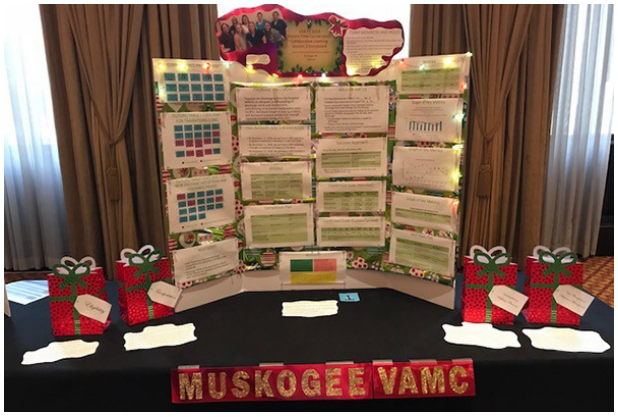
2018 National Forum on Quality Improvement in Health Care (virtual) (Office of Quality, Safety and Value/Institute for Healthcare Improvement)
December 12-13

Improvement Forum Call: Strategies for Improving Psychological Safety in Vermont (National Center for Ethics in Health Care)
December 17
Skype/Lync and VANTS Conference Call

Improvement Forum Call: Topic TBD (National Center for Ethics in Health Care)
December 24
Skype/Lync and VANTS Conference Call



The Muskogee team displays their Team Storyboards during Learning Session 3 of the Patient Flow Coordination Collaborative, December 11-13.

January

Clinical Team Training Champion Course (National Center for Patient Safety)
January 7-11
Marion, IL

Ethics Consultation Coaching Call (National Center for Ethics in Health Care)
January 9
Skype/Lync and VANTS Conference Call

Improvement Forum Call: Professional Boundaries in Ethics (National Center for Ethics in Health Care)
January 14
Skype/Lync and VANTS Conference Call

Improvement Advisor Academy Session 3 (Office of Systems Redesign & Improvement)
January 14-19
Tuscon, AZ

Inpatient Flow Academy Session 1 (Office of Systems Redesign & Improvement)
January 29-31
Long Beach, CA

February

Patient Flow Coordination Collaborative Team Celebration and Graduation (Office of Systems Redesign & Improvement and the Office of Emergency Medicine)
February14
Adobe Connect and VANTS Conference Call